WEST Search History

Hide Items | Restore | Clear | Cancel

DATE: Wednesday, October 31, 2007

Hide?	Set Name	Query	Hit Count
	DB=PGPB,USPT; PLUR=YES; OP=ADJ		
☐	L4	L3 and (sequential near chemotherap$)	3
☐	L3	L1 and (cancer or tumor or neoplas$ or carcinoma or adenocarcinoma)	869
☐	L2	L1 and ((dose-dense) or (dose density))	1
☐	L1	514/34.icls. or 514/34.ccls. or 514/90.icls. or 514/90.ccls. or 514/511.icls. or 514/511.ccls.	1082

END OF SEARCH HISTORY

```
  FILE 'REGISTRY' ENTERED AT 13:32:07 ON 31 OCT 2007
L1             1 S DOXORUBICIN/CN
L2             1 S PACLITAXEL/CN
L3             1 S CYCLOPHOSPHAMIDE/CN

     FILE 'STNGUIDE' ENTERED AT 13:32:32 ON 31 OCT 2007

     FILE 'HCAPLUS' ENTERED AT 13:33:57 ON 31 OCT 2007
L4           977 S L1/THU AND L2/THU AND L3/THU
L5         69888 S (BREAST OR MAMMARY)(W)(CANCER OR TUMOR OR NEOPLAS? OR CARCINO
L6         96180 S (DOSE DENSE) OR SEQUENTIAL
L7           200 S L4 AND L5
L8            32 S L4 AND L6
L9            28 S L4 AND L5 AND L6

     FILE 'STNGUIDE' ENTERED AT 13:34:06 ON 31 OCT 2007

     FILE 'HCAPLUS' ENTERED AT 13:35:23 ON 31 OCT 2007
L10           10 S L9 AND (PY<2003 OR AY<2003 OR PRY<2003)
```

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=> file registry
COST IN U.S. DOLLARS                                    SINCE FILE      TOTAL
                                                           ENTRY    SESSION
FULL ESTIMATED COST                                         0.21       0.21

FILE 'REGISTRY' ENTERED AT 13:32:07 ON 31 OCT 2007
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STRUCTURE FILE UPDATES:   29 OCT 2007  HIGHEST RN 951883-76-4
DICTIONARY FILE UPDATES:  29 OCT 2007  HIGHEST RN 951883-76-4

New CAS Information Use Policies, enter HELP USAGETERMS for details.

TSCA INFORMATION NOW CURRENT THROUGH June 29, 2007

  Please note that search-term pricing does apply when
  conducting SmartSELECT searches.

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predicted properties as well as tags indicating availability of
experimental property data in the original document.  For information
on property searching in REGISTRY, refer to:

http://www.cas.org/support/stngen/stndoc/properties.html

=> s doxorubicin/cn
L1            1 DOXORUBICIN/CN

=> s paclitaxel/cn
L2            1 PACLITAXEL/CN

=> s cyclophosphamide/cn
L3            1 CYCLOPHOSPHAMIDE/CN

=> file stnguide
COST IN U.S. DOLLARS                                    SINCE FILE      TOTAL
                                                           ENTRY    SESSION
FULL ESTIMATED COST                                        15.30      15.51

FILE 'STNGUIDE' ENTERED AT 13:32:32 ON 31 OCT 2007
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FILE CONTAINS CURRENT INFORMATION.
LAST RELOADED: Oct 26, 2007 (20071026/UP).

=> file hcaplus
COST IN U.S. DOLLARS                                    SINCE FILE      TOTAL
                                                           ENTRY    SESSION
FULL ESTIMATED COST                                         0.12      15.63

FILE 'HCAPLUS' ENTERED AT 13:33:57 ON 31 OCT 2007
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FILE COVERS 1907 - 31 Oct 2007 VOL 147 ISS 19
FILE LAST UPDATED: 30 Oct 2007 (20071030/ED)

New CAS Information Use Policies, enter HELP USAGETERMS for details.

This file contains CAS Registry Numbers for easy and accurate substance identification.

=> s l1/thu and l2/thu and l3/thu

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         18276 L1
        948878 THU/RL
          9809 L1/THU
                 (L1 (L) THU/RL)
         14188 L2
        948878 THU/RL
         10202 L2/THU
                 (L2 (L) THU/RL)
         16341 L3
        948878 THU/RL
          7698 L3/THU
                 (L3 (L) THU/RL)
L4         977 L1/THU AND L2/THU AND L3/THU
```

=> s (breast or mammary)(w)(cancer or tumor or neoplas? or carcinoma or adenocarcinoma)

```
         81097 BREAST
         96599 MAMMARY
        335383 CANCER
        427191 TUMOR
        515781 NEOPLAS?
        169571 CARCINOMA
         31561 ADENOCARCINOMA
L5       69888 (BREAST OR MAMMARY)(W)(CANCER OR TUMOR OR NEOPLAS? OR CARCINOMA
               OR ADENOCARCINOMA)
```

=> s (dose dense) or sequential

```
        618912 DOSE
        108053 DENSE
           166 DOSE DENSE
                 (DOSE(W)DENSE)
         96055 SEQUENTIAL
L6       96180 (DOSE DENSE) OR SEQUENTIAL
```

=> s l4 and l5

```
L7         200 L4 AND L5
```

=> s l4 and l6

```
L8          32 L4 AND L6
```

=> s l4 and l5 and l6

```
L9          28 L4 AND L5 AND L6

=> file stnguide

COST IN U.S. DOLLARS                                    SINCE FILE      TOTAL
                                                           ENTRY    SESSION
FULL ESTIMATED COST                                         2.60      18.23

FILE 'STNGUIDE' ENTERED AT 13:34:06 ON 31 OCT 2007
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FILE CONTAINS CURRENT INFORMATION.
LAST RELOADED: Oct 26, 2007 (20071026/UP).

=> file hcaplus
COST IN U.S. DOLLARS                                    SINCE FILE      TOTAL
                                                           ENTRY    SESSION
FULL ESTIMATED COST                                         0.12      18.35

FILE 'HCAPLUS' ENTERED AT 13:35:23 ON 31 OCT 2007
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FILE COVERS 1907 - 31 Oct 2007  VOL 147 ISS 19
FILE LAST UPDATED: 30 Oct 2007  (20071030/ED)

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 This file contains CAS Registry Numbers for easy and accurate
 substance identification.

=> s l9 and (PY<2003 or AY<2003 or PRY<2003)

      22908223 PY<2003
       4466102 AY<2003
       3944929 PRY<2003
L10          10 L9 AND (PY<2003 OR AY<2003 OR PRY<2003)

=> file stnguide

COST IN U.S. DOLLARS                                    SINCE FILE      TOTAL
                                                           ENTRY    SESSION
FULL ESTIMATED COST                                         2.60      20.95

FILE 'STNGUIDE' ENTERED AT 13:35:27 ON 31 OCT 2007
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FILE CONTAINS CURRENT INFORMATION.
LAST RELOADED: Oct 26, 2007 (20071026/UP).
```

=> d l10 1-10 ti abs bib
YOU HAVE REQUESTED DATA FROM FILE 'HCAPLUS' - CONTINUE? (Y)/N:y

L10 ANSWER 1 OF 10 HCAPLUS COPYRIGHT 2007 ACS on STN
TI Dose-dense & sequential adjuvant cancer chemotherapy
AB Breast cancer is treated by (a) administering to a patient in a first plurality of chemotherapy cycles a therapeutically-effective and well-tolerated amount of doxorubicin in a dose-dense protocol; (b) subsequently administering to the patient in a second plurality of chemotherapy cycles a therapeutically-effective and well-tolerated amount of a taxane chemotherapy agent, for example paclitaxel, in a dose-dense protocol; and (c) subsequently administering to the patient in a third plurality of chemotherapy cycles a therapeutically-effective and well-tolerated amount of cyclophosphamide in a dose-dense protocol. Preferably, the dose dense interval between treatments is about 14 days. The number of cycles in each plurality of chemotherapy cycles is suitably 3 or more, preferably 4. Suitable well-tolerated treatment levels are 60 mg/m 2 of doxorubicin, 175 mg/ 2 of paclitaxel, and 600 mg/ 2 of cyclophosphamide. A therapeutically effective amount of G-CSF may also be administered during the intervals between treatments in one or more of the chemotherapy cycles.
AN 2004:995765 HCAPLUS <<LOGINID::20071031>>
DN 141:406045
TI Dose-dense & sequential adjuvant cancer chemotherapy
IN Norton, Larry
PA USA
SO U.S. Pat. Appl. Publ., 17 pp.
CODEN: USXXCO
DT Patent
LA English
FAN.CNT 1

PATENT NO.	KIND	DATE	APPLICATION NO.	DATE
US 2004229826	A1	20041118	US 2003-735180	20031212 <--
PRAI US 2002-432840P	P	20021212 <--		

L10 ANSWER 2 OF 10 HCAPLUS COPYRIGHT 2007 ACS on STN
TI The impact of induction duration and the number of high-dose cycles on the long-term survival of women with metastatic breast cancer treated with high-dose chemotherapy with stem cell rescue: An analysis of sequential phase I/II trials from the Dana-Farber/Beth Israel STAMP program
AB Although high-dose chemotherapy (HDC) with stem cell rescue for the treatment of women with metastatic breast cancer (MBC) is currently a controversial strategy, we report the long-term outcomes of women undergoing high-dose therapy for MBC over the past 12 yr while participating in a sequence of research studies transitioning between a single to a double intensification approach. Univariate and multivariate analyses provide a framework to understand the prognostic factors important for event-free and overall survival. Between May 1988 and Apr. 1998, we enrolled 188 women with MBC into 3 trials of previously reported sequential transplantation strategies. Trial I (long induction/single transplantation) accepted 62 women in partial or complete response to an unspecified induction therapy and treated them with high-dose CTCb (cyclophosphamide, thiotepa, and carboplatin) supported by marrow or peripheral blood progenitor cells (PBPC). Trial II (long induction/double transplantation) accepted 68 women in partial or complete response to an unspecified induction therapy, and mobilized stem cells with 2 cycles of AF (doxorubicin and 5-fluorouracil) with granulocyte

colony-stimulating factor (G-CSF). These women then received 1 cycle of high-dose single-agent melphalan followed 3 to 5 wk later by CTCb, each with marrow or PBPC support. Trial III (short induction/double transplantation) enrolled 58 women prior to chemotherapy treatment for metastatic disease. Induction/mobilization consisted of 2 cycles given 14 days apart of doxorubicin and G-CSF. In contrast to trials I and II, patients with stable disease or better response to induction were eligible to proceed ahead with 2 cycles of HDC, 1 being CTCb and the other being dose escalated paclitaxel together with high-dose melphalan (TxM). These 2 HDC regimens were administered 5 wk apart. TxM was given first in 32 patients and CTCb was given first in 26 patients. The median follow-up periods for trials I, II, and III were 98, 62, and 39 mo from the initiation of induction chemotherapy and 92, 55, and 36 mo from last high-dose therapy, resp. The patient characteristics upon entry into these trials were similar. Important differences were that only those patients achieving a partial response or better to induction therapy were enrolled and analyzed for trials I and II, but all patients were analyzed on an intent-to-treat basis for trial III, including those who did not receive intensification. The median event-free survival (EFS) times from induction chemotherapy were 13, 19, and 27 mo for trials I, II, and III, resp. (III vs. I + II, P = .0004; III vs. I, P = .0005; III vs. II, P = .005; II vs. I, P = .25). The median overall survival (OS) times from induction chemotherapy were 30, 29, and 57 mo for trials I, II, and III, resp. (III vs. I + II, P = .002; III vs. I, P = .003; III vs. II, P = .009; II vs. I, P = .47). By multivariate Cox regression, participation in the short induction/double transplantation trial III and having no prior adjuvant chemotherapy remained favorable prognostic factors for both EFS and OS. The presence of visceral disease shortened EFS, and hormone sensitivity was of borderline significance. No substantive differences in the characteristics of the patient populations between the 3 trials appeared to interact with outcomes. In conclusion, we found that single transplantation in responding patients after long induction achieves a small cohort of long-term survivors, similar to the results reported by other transplantation centers. Adding a cycle of single-agent high-dose melphalan in the context delayed median time to relapse but did not affect long-term EFS or OS. The double transplantation approach using CTCb and TxM early in the course of treatment was associated with the best EFS and overall survival and was safe, feasible, and tolerable. Treatment duration was only 14 wk, and this treatment option eliminated lengthy induction chemotherapy. Although selection biases may have in part contributed to this effect, a randomized comparison of standard therapy vs. short induction/double transplantation is warranted.

AN 2002:409998 HCAPLUS <<LOGINID::20071031>>
DN 137:41383
TI The impact of induction duration and the number of high-dose cycles on the long-term survival of women with metastatic breast cancer treated with high-dose chemotherapy with stem cell rescue: An analysis of sequential phase I/II trials from the Dana-Farber/Beth Israel STAMP program
AU Elias, A. D.; Ibrahim, J.; Richardson, P.; Avigan, D.; Joyce, R.; Reich, E.; McCauley, M.; Wheeler, C.; Frei, E., III
CS Dana-Farber Cancer Institute, Harvard Medical School, Boston, MA, USA
SO Biology of Blood and Marrow Transplantation (2002), 8(4), 198-205
CODEN: BBMTF6; ISSN: 1083-8791
PB Carden Jennings Publishing
DT Journal
LA English
RE.CNT 35 THERE ARE 35 CITED REFERENCES AVAILABLE FOR THIS RECORD
ALL CITATIONS AVAILABLE IN THE RE FORMAT

L10 ANSWER 3 OF 10 HCAPLUS COPYRIGHT 2007 ACS on STN
TI Doxorubicin followed by sequential paclitaxel and cyclophosphamide versus concurrent paclitaxel and cyclophosphamide: 5-year

results of a Phase II randomized trial of adjuvant dose-dense chemotherapy for women with node-positive breast carcinoma

AB We conducted a randomized Phase II trial to directly compare toxicity, feasibility, and delivered dose intensities of two adjuvant dose-intensive regimens containing doxorubicin, paclitaxel, and cyclophosphamide for patients with node-pos. breast carcinoma. Forty-two patients with resected breast carcinoma involving one or more ipsilateral axillary lymph nodes, were randomized to receive two different schedules of adjuvant chemotherapy using 14-day dosing intervals: either (a) three cycles of doxorubicin 80 mg/m2 as i.v. bolus followed sequentially by three cycles of paclitaxel 200 mg/m2 as a 24-h infusion and then by three cycles of cyclophosphamide 3.0 g/m2 as a 1-h infusion (arm A); or (b) the same schedule of doxorubicin followed by three cycles of concurrent cyclophosphamide and paclitaxel at the same doses (arm B). All cycles were supported by granulocyte colony-stimulating factor administration. Forty-one patients were assessable for toxicity and feasibility; 37 (90%) completed all planned chemotherapy. There was no treatment-related mortality; however, increased toxicity was observed on arm B compared with arm A, manifested by an increase in hospitalization for toxicity, mainly neutropenic fever, and an increased incidence of transfusion of packed RBCs transfusions for anemia. The mean delivered dose intensities for paclitaxel and cyclophosphamide were significantly greater for arm A compared with arm B (P = .01 and P = .05, resp.). There is no long-term, treatment-related toxicity, and no cases of acute myelogenous leukemia or myelodysplastic syndrome have been observed Dose-dense sequential single-agent chemotherapy is more feasible than doxorubicin with subsequent concurrent paclitaxel and cyclophosphamide.

AN 2002:51000 HCAPLUS <<LOGINID::20071031>>

DN 136:256842

TI Doxorubicin followed by sequential paclitaxel and cyclophosphamide versus concurrent paclitaxel and cyclophosphamide: 5-year results of a Phase II randomized trial of adjuvant dose-dense chemotherapy for women with node-positive breast carcinoma

AU Fornier, Monica N.; Seidman, Andrew D.; Theodoulou, Maria; Moynahan, Mary Ellen; Currie, Violante; Moasser, Mark; Sklarin, Nancy; Gilewski, Theresa; D'Andrea, Gabriella; Salvaggio, Rori; Panageas, Kathy S.; Norton, Larry; Hudis, Clifford

CS Breast Cancer Medicine Service, Weill Medical College of Cornell University, New York, NY, 10021, USA

SO Clinical Cancer Research (2001), 7(12), 3934-3941
CODEN: CCREF4; ISSN: 1078-0432

PB American Association for Cancer Research

DT Journal

LA English

RE.CNT 26 THERE ARE 26 CITED REFERENCES AVAILABLE FOR THIS RECORD
ALL CITATIONS AVAILABLE IN THE RE FORMAT

L10 ANSWER 4 OF 10 HCAPLUS COPYRIGHT 2007 ACS on STN

TI Risk of pneumonitis in breast cancer patients treated with radiation therapy and combination chemotherapy with paclitaxel

AB Some chemotherapy (CT) drugs, including taxanes, may enhance the effectiveness of radiation therapy (RT). However, combining these therapies may increase the incidence of radiation pneumonitis, a lung inflammation. In a retrospective cohort study, we evaluated the incidence of radiation pneumonitis in breast cancer patients treated with RT and standard adjuvant CT by use of doxorubicin (Adriamycin) and cyclophosphamide, with and without paclitaxel. Forty-one patients with breast cancer were treated with RT and adjuvant CT, including paclitaxel. Paclitaxel and RT (to breast-chest wall in all and lymph nodes in some) were delivered sequentially in 20 patients and concurrently in 21 patients. Paclitaxel was given weekly in some patients

and every 3 wk in other patients. The incidence of radiation pneumonitis was compared with that among patients in our database whose treatments did not include paclitaxel (n = 1286). The percentage of the lung volume irradiated was estimated The Cox proportional hazards model was used to find covariates that may be associated with the observed outcomes. All P values were two-sided. Radiation pneumonitis developed in six of the 41 patients. Three patients received paclitaxel concurrently with RT, and three received it sequentially (P = .95). The mean percentage of lung volume irradiated was 20% in patients who developed radiation pneumonitis and 22% in those who did not (P = .6). For patients treated with CT including paclitaxel, the crude rate of developing radiation pneumonitis was 14.6% (95% confidence interval [CI] = 5.6% to 29.2%). For patients treated with CT without paclitaxel, the crude rate of pneumonitis was 1.1% (95% CI = 0.2% to 2.3%). The difference between the crude rates with or without paclitaxel is highly statistically significant (P<.0001). The mean time to develop radiation pneumonitis in patients treated concurrently with RT and paclitaxel was statistically significantly shorter in patients receiving paclitaxel weekly than in those receiving it every 3 wk (P = .002). The use of paclitaxel and RT in the primary treatment of breast cancer should be undertaken with caution. Clin. trials with the use of combination CT, including paclitaxel plus RT, whether concurrent or sequential, must evaluate carefully the incidence of radiation pneumonitis.

AN 2002:13008 HCAPLUS <<LOGINID::20071031>>
DN 136:210193
TI Risk of pneumonitis in breast cancer patients treated with radiation therapy and combination chemotherapy with paclitaxel
AU Taghian, Alphonse G.; Assaad, Sherif I.; Niemierko, Andrzej; Kuter, Irene; Younger, Jerry; Schoenthaler, Robin; Roche, Maria; Powell, Simon N.
CS Department of Radiation Oncology, Harvard Medical School, Massachusetts General Hospital, Boston, MA, 02114, USA
SO Journal of the National Cancer Institute (2001), 93(23), 1806-1811
CODEN: JNCIEQ; ISSN: 0027-8874
PB Oxford University Press
DT Journal
LA English
RE.CNT 28 THERE ARE 28 CITED REFERENCES AVAILABLE FOR THIS RECORD
ALL CITATIONS AVAILABLE IN THE RE FORMAT

L10 ANSWER 5 OF 10 HCAPLUS COPYRIGHT 2007 ACS on STN
TI Doxorubicin and taxane combination regimens for metastatic breast cancer: focus on cardiac effects
AB A review. Investigation of the combination of the taxanes with doxorubicin in the treatment of breast cancer has logically progressed, with the ultimate goal of identifying a safe and effective regimen for use in the adjuvant setting. Initial phase II findings of the concurrent doxorubicin/paclitaxel combination resulted in substantial response rates, but at a high cost. A much higher percentage of patients than expected developed anthracycline-induced cardiomyopathy. Subsequent phase II and phase III trials have determined administration schedules of doxorubicin/paclitaxel that reduce the risk for cardiotoxicity. However, the overall response rate is only modestly improved over sequential single-agent therapy or standard doxorubicin-containing combination therapy. The lack of cardiotoxicity with docetaxel, its high antitumor activity, and its linear pharmacokinetics have made it an attractive taxane for combination with doxorubicin. In addition, it is easily administered in the outpatient setting. Phase I/II trials of the combination of doxorubicin/docetaxel resulted in high response rates with a lack of adverse modification of anthracycline-induced cardiomyopathy. These findings have been confirmed in a large phase III randomized trial where overall response rates and time to disease progression were significantly improved, but the incidence of

cardiomyopathy was not different for the doxorubicin/docetaxel vs. doxorubicin/cyclophosphamide (AC) regimen. Ongoing studies are underway to assess the role of the doxorubicin/docetaxel combination in the adjuvant setting as primary chemotherapy in the neoadjuvant setting. It is here that the most benefit on survival of breast cancer patients is likely to be shown. At the same time, it is in the adjuvant setting where the absence of potentially late cardiac and other toxicities must be assured.

AN 2001:715318 HCAPLUS <<LOGINID::20071031>>
DN 136:31169
TI Doxorubicin and taxane combination regimens for metastatic breast cancer: focus on cardiac effects
AU Valero, Vicente; Perez, Edith; Dieras, Veronique
CS Department of Breast Medical Oncology, The University of Texas, M. D. Anderson Cancer Center, Houston, TX, 77030-4009, USA
SO Seminars in Oncology (2001), 28(4, Suppl. 12), 15-23
CODEN: SOLGAV; ISSN: 0093-7754
PB W. B. Saunders Co.
DT Journal; General Review
LA English
RE.CNT 34 THERE ARE 34 CITED REFERENCES AVAILABLE FOR THIS RECORD
ALL CITATIONS AVAILABLE IN THE RE FORMAT

L10 ANSWER 6 OF 10 HCAPLUS COPYRIGHT 2007 ACS on STN
TI Double high-dose chemotherapy with stem cell rescue (HD-SCR) in patients with breast cancer - effect of sequence
AB A preliminary anal. of our double high-dose chemotherapy with stem cell rescue (HD-SCR) clin. trial for breast cancer, and preclin. cross-resistant studies, suggested that melphalan (M) adversely affected response to subsequent chemotherapy, i.e., that the sequence of alkylating agents (AAs) might affect response. We, therefore, constructed and examined preclin. models to determine whether prior exposure to M, in fact, adversely affected response to other therapy. The purpose of the study was to determine whether the sequence of AAs, specifically the prior use of M, adversely affected response to subsequent treatment. The methods employed were the following: (1) Human tumor cell lines rendered resistant by in vitro sequential exposure to five different AAs were developed. The resistant cell lines were examined for cross-resistance to alkylating and other agents. (2) In vivo studies in the p388 mouse leukemia for resistance and cross-resistance among the AAs. (3) In vivo studies of the effect of sequence of AAs on response in mice bearing EMT6 breast cancer. (4) The double transplant model was developed in the mouse and the sequence of high-dose AAs was studied. (5) Biochem. and reverse transcriptase-polymerase chain reaction (RT-PCR) studies of the various resistant tumor cell lines. Results: (1) The in vitro human tumor cells resistant to M were cross-resistant in 57% of tests to other AAs. In contrast, resistance for other AAs crossed to other agents in only 10 to 20% of tests. (2) The in vivo studies of p388 indicated that resistance to M commonly crossed to other AAs and many non-AAs. (3) The results for the mouse breast cancer (EMT6) studies of the sequence of AAs again indicated that M employed first markedly reduced responsiveness to subsequent treatment, particularly with AAs. (4) The double transplant model: again, M first markedly reduced response to other agents. (5) The in vitro resistant human tumor cell lines, particularly the breast cancer cell line MCF7, were found to contain high concns. of glutathione S1 transferase gamma, which is consistent with that mechanism being responsible for resistance. Thus, the sequence of alkylating agent treatment may substantially influence response. Melphalan, particularly, produces resistance that commonly crosses to the other AAs. Mechanistic studies indicate significant changes in glutathione S1 transferase, a known mechanism for broadly based resistance to AAs.

AN 2000:63830 HCAPLUS <<LOGINID::20071031>>
DN 133:114668
TI Double high-dose chemotherapy with stem cell rescue (HD-SCR) in patients

with breast cancer - effect of sequence
AU Frei, Emil III; Ara, Gulshan; Teicher, Beverly; Bunnell, Craig; Richardson, Paul; Wheeler, Catherine; Tew, Kenneth; Elias, Anthony
CS Department of Adult Oncology, Dana Farber Cancer Institute, Harvard Medical School, Boston, MA, 02115, USA
SO Cancer Chemotherapy and Pharmacology (2000), 45(3), 239-246
CODEN: CCPHDZ; ISSN: 0344-5704
PB Springer-Verlag
DT Journal
LA English
RE.CNT 37 THERE ARE 37 CITED REFERENCES AVAILABLE FOR THIS RECORD
ALL CITATIONS AVAILABLE IN THE RE FORMAT

L10 ANSWER 7 OF 10 HCAPLUS COPYRIGHT 2007 ACS on STN
TI Sequential dose-dense doxorubicin, paclitaxel, and cyclophosphamide for resectable high-risk breast cancer: feasibility and efficacy
AB Dose-dense chemotherapy is predicted to be a superior treatment plan. Therefore, we studied dose-dense doxorubicin, paclitaxel, and cyclophosphamide (A → T → C) as adjuvant therapy. Patients with resected breast cancer involving four or more ipsilateral axillary lymph nodes were treated with nine cycles of chemotherapy, using 14-day intertreatment intervals. Doses were as follows: doxorubicin 90 mg/m2 + 3, then paclitaxel 250 mg/m2/24 h + 3, and then cyclophosphamide 3.0 g/m2 + 3; all doses were given with s.c. injections of 5 μg/kg granulocyte colony-stimulating factor on days 3 through 10. Amenorrheic patients with hormone receptor-pos. tumors received tamoxifen 20 mg/day for 5 yr. Patients treated with breast conservation, those with 10 or more pos. nodes, and those with tumors larger than 5 cm received radiotherapy. Between Mar. 1993 and June 1994, we enrolled 42 patients. The median age was 46 yr (range, 29 to 63 yr), the median number of pos. lymph nodes was eight (range, four to 25), and the median tumor size was 3.0 cm (range, 0 to 11.0 cm). The median intertreatment interval was 14 days (range, 13 to 36 days), and the median delivered dose-intensity exceeded 92% of the planned dose-intensity for all three drugs. Hospital admission was required for 29 patients (69%), and 28 patients (67%) required blood product transfusion. No treatment-related deaths or cardiac toxicities occurred. Doxorubicin was dose-reduced in four patients (10%) and paclitaxel was reduced in eight (20%). At a median follow-up from surgery of 48 mo (range, 3 to 57 mo), nine patients (19%) had relapsed, the actuarial disease-free survival rate was 78% (95% confidence interval, 66% to 92%), and four patients (10%) had died of metastatic disease. Dose-dense sequential adjuvant chemotherapy with doxorubicin, paclitaxel, and cyclophosphamide (A → T → C) is feasible and promising. Several ongoing phase III trials are evaluating this approach.
AN 1999:50879 HCAPLUS <<LOGINID::20071031>>
DN 130:232080
TI Sequential dose-dense doxorubicin, paclitaxel, and cyclophosphamide for resectable high-risk breast cancer: feasibility and efficacy
AU Hudis, C.; Seidman, A.; Baselga, J.; Raptis, G.; Lebwohl, D.; Gilewski, T.; Moynahan, M.; Sklarin, N.; Fennelly, D.; Crown, J. P. A.; Surbone, A.; Uhlenhopp, M.; Riedel, E.; Yao, T. J.; Norton, L.
CS Breast and Gynecologic Cancer Medicine Service, Department of Medicine, Memorial Sloan-Kettering Cancer Center, New York, NY, 10024, USA
SO Journal of Clinical Oncology (1999), 17(1), 93-100
CODEN: JCONDN; ISSN: 0732-183X
PB Lippincott Williams & Wilkins
DT Journal
LA English
RE.CNT 35 THERE ARE 35 CITED REFERENCES AVAILABLE FOR THIS RECORD
ALL CITATIONS AVAILABLE IN THE RE FORMAT

L10 ANSWER 8 OF 10 HCAPLUS COPYRIGHT 2007 ACS on STN
TI Sequential administration of doxorubicin and paclitaxel followed by cyclophosphamide, methotrexate, and 5-fluorouracil combination (CMF) in women with metastatic breast cancer
AB Although the combination of paclitaxel with doxorubicin has yielded high response rates in metastatic breast cancer, severe cardiotoxic events were reported in several patients. The rationale for this study was to evaluate the activity of paclitaxel/doxorubicin combination in patients with this disease but to avoid excessive cardiotoxicity. Therefore, 4 cycles of doxorubicin/paclitaxel were administered followed by 6 cycles of standard cyclophosphamide, methotrexate, and 5-fluorouracil (CMF) regimen. Study medication consisted of doxorubicin 60 mg/m2 as a 15-min i.v. infusion followed by paclitaxel 175 mg/m2 as a 3-h infusion. CMF regimen consisted of cyclophosphamide 600 mg/m2 as 1-h i.v. infusion followed by methotrexate 40 mg/m2 and 5-fluorouracil 600 mg/m2 bolus injection. The main toxicity of doxorubicin/paclitaxel treatment phase was neutropenia (WHO grade 3/4, 58%), but only one cardiac adverse event was observed Toxicities of the CMF treatment phase were not significant. Of 24 patients evaluable for response, 2 (8%) had complete responses and 11 (46%) achieved partial response. Ten addnl. patients (42%) had stable disease. The median time to progression was 12 mo and the median overall survival was 18.5 mo. The sequential administration of doxorubicin and paclitaxel followed by CMF appeared active and well tolerated in patients with metastatic breast cancer.
AN 1998:712907 HCAPLUS <<LOGINID::20071031>>
DN 129:310571
TI Sequential administration of doxorubicin and paclitaxel followed by cyclophosphamide, methotrexate, and 5-fluorouracil combination (CMF) in women with metastatic breast cancer
AU Papadimitriou, Christos A.; Dimopoulos, Meletios A.; Ampela, Constantina; Louvrou-Fertaki, Androniki; Anagnostopoulos, Athanassios; Athanassiades, Peter; Stamatelopoulos, Stamatios; Keramopoulos, Antonios
CS Department Clinical Therapeutics, Alexandra Hospital, Athens, 14561, Greece
SO Oncology (1998), 55(6), 533-537
CODEN: ONCOBS; ISSN: 0030-2414
PB S. Karger AG
DT Journal
LA English

L10 ANSWER 9 OF 10 HCAPLUS COPYRIGHT 2007 ACS on STN
TI Sequential adjuvant therapy: The Memorial Sloan-Kettering Cancer Center experience
AB Adjuvant chemotherapy has a real but modest impact on the disease-free and overall survival of patients with breast cancer. Recent attempts to improve its effectiveness have focused on dose intensity and new agents. Sequential therapy maximized dose intensity while limiting overlapping toxicity. Sequential therapy using doxorubicin followed by cyclophosphamide/methotrexate/5-fluorouracil (CMF) has been found superior in patients with high-risk resectable breast cancer. The novel chemotherapy agent paclitaxel (Taxol; Bristol-Myers Squibb Company, Princeton, NJ) is now known to be highly active in advanced breast cancer and appears to be clin. non-cross-resistant with doxorubicin. Therefore, this drug is being studied as a component of the next generation of adjuvant chemotherapy regimens. The most appropriate way to incorporate paclitaxel has not yet been defined, but its concurrent administration with other agents has, in some cases, been troublesome. Based on the demonstrated advantage of the sequential plan for doxorubicin and CMF, we conducted a series of pilot trials testing sequential high-dose therapy. Initially, we studied multiple cycles of doxorubicin followed by cyclophosphamide; we later added paclitaxel to this regimen.

These phase II studies demonstrate the feasibility of sequential therapy with doxorubicin, paclitaxel, and cyclophosphamide, and early disease-free survival results are promising. Cooperative group projects are under way or planned to further define the activity of these regimens.

AN 1996:235572 HCAPLUS <<LOGINID::20071031>>
DN 124:332025
TI Sequential adjuvant therapy: The Memorial Sloan-Kettering Cancer Center experience
AU Hudis, Clifford; Seidman, Andrew; Raptis, George; Fennelly, David; Gilewski, Theresa; Baselga, Jose; Theodoulou, Maria; Sklarin, Nancy; Moynahan, Mary; et al.
CS Department Medicine, Memorial Sloan-Kettering Cancer Center, New York, NY, USA
SO Seminars in Oncology (1996), 23(1, Suppl. 1), 58-64
CODEN: SOLGAV; ISSN: 0093-7754
PB Saunders
DT Journal
LA English

L10 ANSWER 10 OF 10 HCAPLUS COPYRIGHT 2007 ACS on STN
TI Sequential adjuvant therapy with doxorubicin/paclitaxel/cyclopho sphamide for resectable breast cancer involving four or more axillary nodes
AB The results of both retrospective and prospective studies suggest that the effectiveness of systemic adjuvant chemotherapy with doxorubicin and cyclophosphamide for breast cancer may be related to the dose intensity of these agents. Recent trials also have demonstrated the high activity of paclitaxel (Taxol; Bristol-Myers Squibb Company, Princeton, NJ) against metastatic breast cancer. Clin., paclitaxel appears to be non-cross-resistant with doxorubicin, but the unique and overlapping toxicities of these three agents might preclude concurrent adjuvant administration. A possible solution is sequential rather than concurrent administration, an approach that kinetic modeling predicts to be superior. A pilot study testing dose-intensive sequential administration of doxorubicin/paclitaxel/cyclophosphamide enrolled 42 patients with a median age of 42 yr who had resected breast cancer metastatic to four or more ipsilateral axillary lymph nodes. I.v. treatment, given at 14-day intervals, began with three cycles of doxorubicin 90 mg/m2, followed by three cycles of paclitaxel 250 mg/m2, given as a 24-h infusion, and, finally, three cycles of cyclophosphamide 3 g/m2. Selected patients received radiotherapy. The median number of pos. lymph nodes was eight (range, four to 25), and the median tumor size was 3.0 cm (range, 0 to 11.0 cm). Granulocyte colony-stimulating factor support was given. Both hematol. and nonhematol. toxicity were substantial but manageable. Hospital admission was necessary in 62 (17%) of 369 chemotherapy cycles in 29 patients (69%). As planned, the median intertreatment interval was 14 days through all nine cycles of therapy, and the median delivered dose intensity exceeded 98% for all three agents. The median follow-up from local control surgery in Dec. 1994 was 448 days (range, 82 to 632 days). Three patients (7.2%) had disease relapses, one during the doxorubicin portion of treatment and two (4.9%) who had completed treatment with all three agents. Sequential dose-intensive therapy with doxorubicin/paclitaxel/cyclophosphamide has manageable toxicity and, with short follow-up, is a promising new regimen suitable for randomized testing.
AN 1996:163649 HCAPLUS <<LOGINID::20071031>>
DN 124:278222
TI Sequential adjuvant therapy with doxorubicin/paclitaxel/cyclopho sphamide for resectable breast cancer involving four or more axillary nodes
AU Hudis, Clifford A.; Seidman, Andrew D.; Baselga, Jose; Raptis, George; Lebwohl, David; Gilewski, Teresa; Currie, Violante; Moynahan, Mary Ellen; Sklarin, Nancy; et al.

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SO Seminars in Oncology (1995), 22(6, Suppl. 15), 18-23
CODEN: SOLGAV; ISSN: 0093-7754
PB Saunders
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